

May 22, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-1014-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Physical Medicine and Rehabilitation. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ was walking up stairs in a high rise complex and he was at the top of the second floor when he reached for the handrail, missed, and fell backward, falling down the entire flight of stairs and injuring his left side. After the fall, he started having pain in his neck, upper back, lower back and pain that radiated into his right lower extremity with associated numbness and tingling. He was initially treated at the Clinic by ___ and given physical therapy. He underwent a CT of the lumbar spine on 1/27/03. A L5/S1 3 mm posterior herniation with encroachment on the thecal sac was noted, as well as spina bifida occulta. He changed treating doctors to ___, who valued him and started a therapy program, changed his medications to Norco, Zanaflex and Neurontin. A lower extremity EMG and nerve conduction studies were done that identified right-sided S1 radiculopathy. ___ recommended the use of an Orthotrac Pneumatic Vest as a method of allowing the patient to tolerate more upright time without having pain.

REQUESTED SERVICE

The purchase of an Orthotrac Pneumatic Vest is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

___ provided considerable online information about the research projects that he did not feel supported the use of the Orthotrac Pneumatic Vest. There was no medical documentation from the treating doctor to indicate that this patient had responded to any kind of offloading devices in his therapies, or that he responded to any therapies that involved decreased weight-bearing. Therefore, the evidence presented in this case does not justify the purchase of this device.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective *spinal surgery* decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other *prospective (preauthorization) medical necessity* disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).